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Cognitive-Behavioral Therapy for Body Dysmorphic Disorder by Proxy

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Body dysmorphic disorder (BDD) is a distressing or impairing preoccupation with a perceived defect in physical appearance. BDD by proxy (BDDBP) is a significant but understudied variant of BDD in which the primary preoccupation involves perceived imperfections of another person. Like BDD, individuals with BDDBP engage in time-consuming rituals to "fix" the other person's appearance or alleviate distress. Avoidance is common and the impact of BDDBP on social functioning is profound. Cognitive-behavioral therapy (CBT) is the best-studied and most promising psychological treatment for BDD, but no studies have examined its generalizability to the BDDBP variant. We tested feasibility, acceptability, and treatment outcome of CBT modified for BDDBP in a sample of 6 adults with primary BDDBP. Treatment was delivered in weekly individual sessions over 12–20 weeks. Mean symptom severity (BDDBP-YBOCS) dropped from the moderately severe range at pretreatment to the subclinical range at posttreatment, $t(6) = 10.7$, $p < .001$, $d = 3.3$. One hundred percent of treatment completers were responders (≥30% reduction in BDDBP-YBOCS). Insight also improved. Treatment gains were maintained at 3-month follow-up. To our knowledge, this represents the first treatment study for BDDBP.

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Body Dysmorphic Disorder By Proxy (BDDBP) is characterized by preoccupation with perceived imperfections in *another person's* appearance (American Psychiatric Association [APA], 2013). BDDBP is not recognized as a unique entity in DSM-5 (APA, 2013), but rather, may be diagnosed as a variant of body dysmorphic disorder (BDD). BDDBP differs from BDD proper in that the focus of excessive preoccupation involves another person's appearance rather than one's own appearance. However, similar to BDD, individuals with BDDBP are markedly distressed and/or impaired by their preoccupation (e.g., Atiullah & Phillips, 2001; Greenberg et al., 2013). Individuals spend excessive time on rituals aimed at alleviating their own distress or "fixing" the appearance of the person of concern (PoC), including scrutinizing the PoC, comparing the PoC's appearance to that of others, or suggesting cosmetic procedures. Individuals may experience elevated rates of suicidal thoughts and behaviors, troubled interpersonal relationships, and extreme shame (Atiullah & Phillips, 2001; Josephson & Hollander, 1997). Preliminary evidence from case reports suggests that BDDBP may emerge in an individual previously concerned with his or her own appearance (Atiullah & Phillips, 2001; Josephson & Hollander, 1997). This has contributed to the conceptualization of BDDBP as a form of core BDD pathology (Josephson & Hollander, 1997; Persaud, 1998). BDDBP has also been associated with comorbid obsessive–compulsive disorder (Josephson & Hollander, 1997).

The only empirical study on BDDBP (Greenberg et al., 2013) reported on the phenomenology of BDDBP in 11 individuals. Information about the psychopathology and treatment of BDDBP is otherwise limited to case reports (Atiullah & Phillips, 2001; Bakhla, Prakriti, & Kumar, 2012; Bouman & Gofers, 2016; Cleveland, DeLaPaz, Fawwaz, & Challop, 2009; Godden, 1999; Josephson & Hollander, 1997; Laugharne, Upex, & Palazidou, 1998). Of the seven published case reports, two describe only the clinical features of BDDBP, and five offer very brief mention of treatment.

Phillips first described the phenomenon of BDDBP in *The Broken Mirror* (1996), in which a mother so worried about her daughter's nose that she would push on it to make it straight, even though the daughter did not worry about her own appearance. Josephson and Hollander (1997) presented two cases of BDDBP: a 39-year-old male rabbi preoccupied with the facial and body hair of his children, and a 32-year-old female concerned with her fiancé's nose. Both patients had a history of OCD and BDD before developing concerns around another person's appearance. Both received behavior therapy consisting of exposure and response prevention; the first patient additionally tried a number of pharmacotherapy trials. The first patient's BDD and OCD improved (*much improvement* on the Clinical Global Impressions [CGI] scale =2); however, no change was observed in his BDDBP symptoms (CGI = 4). The second patient reported *very much improvement* (CGI = 1), on BDDBP, specifically reduced distress associated with BDDBP and improved social functioning. The authors also noted the impact of BDDBP on others. The children of the first patient experienced distress related to daily scrutiny by their father and the second patient's fiancé was increasingly angry over her critical nature. Laugharne et al. (1998) described an African-American female in her mid-20s who was so worried her unborn children would inherit their father's flaws (short stature, "slanted eyes," or big mouth) that she aborted the pregnancies. No treatment was described. Godden (1999) reported on a mother so preoccupied by defects in her 17-year-old daughter's face following osteotomy and secondary septoplasty that she deemed her "too ugly" to go to school or on a foreign exchange. Despite postoperative satisfaction from her daughter and the medical team, the mother insisted on additional corrections. Atiullah and Phillips (2001) reported on the fatal case of a 63-year-old male preoccupied by his daughter's hair. The man was treated with sertraline (100 mg/day) and clonazepam/lorazepam in a partial hospital setting for 5 weeks, but committed suicide several weeks after discharge. Cleveland et al. (2009) described a 30-year-old male with refractory OCD and BDD who subsequently developed BDDBP (fear that his parents were ugly and that he looked like them). The patient had a history of multiple symptom exacerbations following streptococcal and H. Pylori infections. Following treatment with high dose glycine over 5 years, the patient showed improvement in OCD and BDD symptoms, although no standardized measures of symptom improvement were described. No mention was made of the effect of treatment on BDDBP. Bakhla et al. (2012) reported on a 28-year-old woman preoccupied with perceived deformities of her daughter's appearance. The patient's symptoms first manifested as primary BDD (preoccupation with her own stature, facial deformity), and after getting married, spread to concerns regarding her husband's appearance (disproportionately big face). She then became so worried that their baby would share her physical ugliness, she attempted an abortion. Since the birth of her daughter, the patient became preoccupied with perceived deformities in her daughter's face. In response to 12 weeks of combined pharmacotherapy (venlafaxine 150 mg/*d* and trifluoperazine 10 mg/*d*) and cognitive-behavioral therapy, the patient's BDD and BDDBP symptoms improved from the moderately severe to subthreshold range on the BDD-YBOCS, with a greater improvement in the concerns of her daughter relative to concerns around her own appearance (from a total score of 32 to 12 and from 30 to 6 respectively). Comorbid depression also improved. In this and previous cases, treatment was described briefly, and CBT was often combined with pharmacotherapy. Thus, it is difficult to delineate the effects of specific approaches. Bouman and Gofers (2016) described a 36-year-old man preoccupied by his wife's buttocks who had 13 sessions of CBT. Bouman and Gofers provide a detailed description of the CBT formulation and specific course of treatment, which included psychoeducation, cognitive interventions, and behavioral strategies including exposure and response prevention and attention retraining. However, in addition to the patient's individual CBT sessions, the treatment also included three couple's sessions, pharmacotherapy (6 weeks of citalopram), and six individual sessions for the patient's wife with a different therapist. Based on reliable change indices (RCI), treatment was associated with a reduction in BDDBP symptoms (RCI = 10.6) and improvement in anxiety and depressive symptoms. Improvement in marital functioning was also observed.

These case reports describe BDDBP and some briefly mention treatment. However, to date there has been no standardized diagnosis or assessment of BDDBP. Similarly, treatment of BDDBP has not been studied systematically. Several studies have found CBT to successfully reduce BDD severity and